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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **RAYMOND JOHN BOISVERT** **210 Park Avenue** **Worcester, Massachusetts 01610** **Registered Nurse License Number 478840** Respondent.	Case Number 2013-259 **ACCUSATION**

Complainant alleges:

PARTIES

1. Complainant Louise R. Bailey, M.Ed., R.N., brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing (Board), Department of Consumer Affairs.

2. On or about May 31, 1992, the Board issued Registered Nurse License Number 478840 to respondent Raymond John Boisvert. This registered nurse license expired on January 31, 2012, and has not been renewed.

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

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4. Section 118, subdivision (b), provides:

"The suspension, expiration, or forfeiture by operation of law of a license issued by a board in the department, or its suspension, forfeiture, or cancellation by order of the board or by order of a court of law, or its surrender without the written consent of the board, shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute of continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the licensee on any such ground."

5. Section 2750 provides:

"Every certificate holder or licensee, including licensees holding temporary licenses, or licensees holding licenses placed in an inactive status, may be disciplined as provided in this article [Article 3 of the Nursing Practice Act (Bus. & Prof. Code, § 2700 et seq.)]. As used in this article, 'license' includes certificate, registration, or any other authorization to engage in practice regulated by this chapter. The proceedings under this article shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code [the Administrative Procedure Act], and the board shall have all the powers granted therein."

6. Section 2764 provides:

"The lapsing or suspension of a license by operation of law or by order or decision of the board or a court of law, or the voluntary surrender of a license by a licentiate shall not deprive the board of jurisdiction to proceed with any investigation of or action or disciplinary proceeding against such license, or to render a decision suspending or revoking such license."

STATUTORY PROVISIONS

7. Section 2761 provides, in pertinent part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

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"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

8. Section 2762 provides, in pertinent part:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act] it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, a controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

. . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

9. California Code of Regulations, title 16, section 1442, provides:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

10. California Code of Regulations, title 16, section 1443, provides:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

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11. California Code of Regulations, title 16, section 1443.5, provides:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

COST RECOVERY

12. Section 125.3, subdivision (a), provides:

"Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board upon request of the entity bringing the proceedings, the administrative law judge may direct a

licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case."

DRUGS

13. Fentanyl Citrate (Fentanyl) is a strong analgesic, pharmacodynamically similar to Merperdine and Morphine. It is used preoperatively, during surgery and in the immediate postoperative period. Among other applications, the drug may be used in the management of breakthrough cancer pain. Fentanyl is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c)(8), and is a dangerous drug within the meaning of Business and Professions Code section 4022.

14. Lorazepam (Ativan) is used for anxiety and sedation in the management of anxiety disorder for short-term relief from the symptoms of anxiety or anxiety associated with depressive symptoms. Ativan is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(16), and is a dangerous drug within the meaning of Business and Professions Code section 4022.

15. Morphine Sulfate (Morphine), a central nervous system depressant, is a systemic narcotic and analgesic used in the management of pain. Morphine is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(L), and is a dangerous drug within the meaning of Business and Professions Code section 4022.

16. Midazolam (Versed) is a benzodiazepine that is used for preoperative sedation, and is particularly useful when anxiety relief and diminished recall are desired. Versed is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(21), and is a dangerous drug within the meaning of Code section 4022.

17. Pyxis is a computerized management, storage, and medication dispensing system manufactured by the Cardinal Health Corporation in Dublin, Ohio. Medical employees are given access to the Pyxis medication unit via password.

FACTUAL BACKGROUND

18. Respondent was employed by Sutter-Solano Medical Center in Vallejo, California, as a registered nurse from about October 2009 until he was terminated on or about October 21,

2010.

19. On or about August 23, 2010, respondent charted that he wasted 87 mgs of Versed. Following standard procedure, respondent had another nurse witness and document the waste. However, this nurse saw respondent in possession of the wasted Versed after the waste depository bin was closed. The nurse reported the incident. The wasted Versed was not found in the closed waste depository bin.

20. This incident triggered an audit of respondent's medications records which showed improper accounting of medications and improper charting. Examples of these improprieties are as follows:

A. **Patient 1**[1]

1) On March 14, 2010, at approximately 1:55 a.m., a nurse began administration of 100 mg Versed in a 100 ml premixed bag of Versed at 4 ml per hour. This medication should have lasted approximately 24 hours.

2) On March 14, 2010, at approximately 2:18 p.m., respondent removed a 100 ml premixed bag of 100 mg Versed from Pyxis. He did not chart administering it, wasting it, or otherwise account for it in any hospital record.

B. **Patient 2**

1) On March 16, 2010, the patient was receiving a Versed drip. At approximately 12:26 p.m., respondent charted on the Medical Administration Record (MAR) that the drip was turned off. He charted in the 24 Hour Patient Care Record that the drip was discontinued between 12:00 p.m. and 1:00 p.m. At approximately 4:54 p.m., respondent charted in the Pyxis record that he wasted 30 mg of Versed.

2) On March 16, 2010, at approximately 3:58 p.m., respondent administered morphine to the patient. He did not chart the patient's pain assessment in any hospital record after administering it.

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[1] The patient names will be released pursuant to a discovery request.

C. **Patient 3**

1) On March 19, 2010, at approximately 8:57 a.m., respondent removed 100 mg Versed in a 100 ml premixed bag from Pyxis. He did not chart administering it, wasting it, or otherwise account for it in any hospital record.

2) On March 26, 2010, at approximately 6:11 a.m., respondent removed 100 mg Versed in a 100 ml premixed bag from Pyxis. He did not chart administering it, wasting it, or otherwise account for it in any hospital record.

3) On March 22, 2010, at approximately 10:06 a.m., respondent charted in the Pyxis record that he wasted 1125 mcg of Fentanyl. The amount withdrawn was 1250 mcg. He did not chart administering, wasting, or otherwise account for the remaining 125 mcg of Fentanyl in any hospital record.

4) On March 22, 2010, at approximately 7:27 a.m., respondent removed 100 mg Versed in a 100 ml premixed bag from Pyxis. At approximately 9:19 a.m., he noted in the MAR a physician order to discontinue Versed. At approximately 10:06 a.m., he charted in the Pyxis record that he wasted 95 ml of the premixed bag of Versed. He did not chart administering, wasting, or otherwise account for the remaining 5 ml of the premixed bag of Versed in any hospital record.

D. **Patient 4**

1) On April 30, 2010, at approximately 11:19 a.m., respondent removed 100 mg Versed in a 100 ml premixed bag from Pyxis. He did not chart administering it, wasting it, or otherwise account for it in any hospital record.

2) On April 30, 2010, at approximately 3:15 p.m., respondent removed 1250 mcg Fentanyl in a 250 ml premixed bag from Pyxis. He did not chart administering it, wasting it, or otherwise account for it in any hospital record.

3) On April 30, 2010, at approximately 5:34 p.m., respondent removed 100 mg Versed in a 100 ml premixed bag from Pyxis. He did not chart administering it, wasting it, or otherwise account for it in any hospital record.

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E. **Patient 5**

1) On May 3, 2010, at approximately 10:56 a.m., respondent administered Morphine to the patient. He did not chart the patient's pain assessment in any hospital record before or after administering it.

2) On May 3, 2010, at approximately 11:19 a.m., respondent administered Morphine to the patient. He did not chart the patient's pain assessment in any hospital record before or after administering it.

3) On May 4, 2010, at approximately 7:52 a.m., respondent administered Morphine to the patient. He did not chart the patient's pain assessment in any hospital record before or after administering it.

F. **Patient 6**

1) On May 29, 2010, at approximately 2:48 p.m., respondent removed 100 mg Versed in a 100 ml premixed bag from Pyxis. He did not chart administering it, wasting it, or otherwise account for it in any hospital record.

2) On May 30, 2010, at approximately 9:15 a.m., respondent administered Morphine to the patient. He did not chart the patient's pain assessment in any hospital record before or after administering it.

G. **Patient 7**

1) On July 4, 2010, at approximately 9:00 a.m., respondent administered Morphine to the patient. He did not chart the patient's pain assessment in any hospital record before or after administering it.

2) On July 4, 2010, at approximately 2:52 p.m., respondent administered Morphine to the patient. He did not chart the patient's pain assessment in any hospital record before or after administering it.

3) On July 4, 2010, at approximately 6:08 p.m., respondent administered Morphine to the patient. He did not chart the patient's pain assessment in any hospital record before or after administering it.

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H. **Patient 9**

1) On July 26, 2010, at approximately 12:06 p.m., respondent removed a 240 ml premixed bag of Ativan from Pyxis. He did not chart administering it, wasting it, or otherwise account for it in any hospital record.

I. **Patient 10**

1) On August 19, 2010, at approximately 2:41 p.m., respondent removed 100 mg Versed in a 100 ml premixed bag from Pyxis. He did not chart administering it, wasting it, or otherwise account for it in any hospital record.

21. Respondent was interviewed by the hospital on or about October 14, 2010. He denied diverting medications but could not account for his charting omissions.

FIRST CAUSE FOR DISCIPLINE
Unprofessional Conduct: Incompetence
(Bus. & Prof. Code, § 2761, subds. (a) & (a)(1)); Cal. Code Regs., tit. 16, § 1443)

22. The allegations of paragraphs 18-21 are realleged and incorporated by reference as if fully set forth.

23. Respondent has subjected his license to disciplinary action for unprofessional conduct under section 2761, subdivision (a), as defined by subdivision (a)(1) and California Code of Regulations, title 16, section 1443. As set forth in paragraphs 18-21 above, he was incompetent and lacked the possession of or failed to exercise that degree of lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse by failing to follow hospital policy regarding, but not limited to, possession, administration, and documentation of controlled substances.

SECOND CAUSE FOR DISCIPLINE
Unprofessional Conduct: Gross Negligence
(Bus. & Prof. Code, § 2761, subds. (a) & (a)(1)); Cal. Code Regs., tit. 16, § 1442)

24. The allegations of paragraphs 18-21 are realleged and incorporated by reference as if fully set forth.

25. Respondent has subjected his license to disciplinary action for unprofessional conduct under section 2761, subdivision (a), as defined by subdivision (a)(1) and California Code of Regulations, title 16, section 1442. As set forth in paragraphs 18-21 above, he was grossly

negligent by manifesting an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse by failing to follow hospital policy regarding, but not limited to, possession, administration, and documentation of controlled substances.

THIRD CAUSE FOR DISCIPLINE
Unprofessional Conduct: Possession of Controlled Substance or Dangerous Drug
(Bus. & Prof. Code, §§ 2761, subd. (a); 2762, subd. (a))

26. The allegations of paragraphs 18-21 are realleged and incorporated by reference as if fully set forth.

27. Respondent has subjected his license to disciplinary action for unprofessional conduct under section 2761, subdivision (a), as defined by section 2762, subdivision (a). As set forth in paragraphs 18-21 above, he repeatedly possessed a greater or lesser amount of controlled substances or dangerous drugs than was accounted for by any record required by law.

FOURTH CAUSE FOR DISCIPLINE
Unprofessional Conduct: False, Grossly Incorrect, or Grossly Inconsistent Entries
(Bus. & Prof. Code, §§ 2761, subd. (a); 2762, subd. (e))

28. The allegations of paragraphs 18-21 are realleged and incorporated by reference as if fully set forth.

29. Respondent has subjected his license to disciplinary action for unprofessional conduct under section 2761, subdivision (a), as defined by section 2762, subdivision (e). As set forth in paragraphs 18-21 above, he made false, grossly incorrect, or grossly inconsistent entries, or failed to make entries, in hospital, patient, and other records pertaining to patient monitoring and the administration of controlled substances.

PRAYER

WHEREFORE, complainant requests that a hearing be held on the matters alleged in this Accusation, and that following the hearing, the Board issue a decision:

1. Revoking or suspending Registered Nurse License Number 478840 issued to Raymond John Boisvert;

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2. Ordering Raymond John Boisvert to pay the Board the reasonable costs of the investigation and enforcement of this case pursuant to Business and Professions Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: October 10, 2012

for LOUISE R. BAILEY, M.Ed., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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